HEALTH CARE LAW ADVISOR ALERT: CORPORATE PRACTICE OF MEDICINE AND FEE SPLITTING–CONSIDERATIONS FOR TELEHEALTH VENTURES

The increase in the use of telemedicine during the COVID-19 pandemic has given rise to new business ventures among medical practices, technology companies and sometimes also venture capitalists. The relationship between and among the medical practice, the technology component and the financiers must be carefully structured to comply with federal and state law. If structured appropriately, licensed medical providers can be relieved of business administrative functions and instead focus on clinical care. Core legal doctrines driving the business structure of health care ventures include: (1) the corporate practice of medicine (the "CPOM") doctrine; (2) illegal fee splitting laws; and (3) federal and state physician self-referral and anti-kickback statutes. This article focuses on the implications of the CPOM and fee splitting doctrines on medical services and health care technology ventures.

Corporate Practice of Medicine

The CPOM doctrine prohibits corporations from practicing medicine or employing a physician to provide medical services. *See* WIS. STAT. §448.03(1) (requiring a license to practice medicine); WIS. STAT. § 448.08(1m) (prohibiting fee splitting with non-physicians). The rationale for the CPOM doctrine is that unlicensed entities are not bound by the ethical rules that govern the quality of care delivered by a physician to a patient. Wisconsin's CPOM doctrine is derived not only from the Wisconsin Medical Practices Act, but also from guidance established in Wisconsin Attorney General Opinions.[1] With respect to legally permissible forms of organization for medical providers, the Wisconsin Statutes expressly permit Wisconsin-licensed health care professionals (including, but not limited, to physicians, chiropractors, dentists, podiatrists, optometrists, nurses, pharmacists, and psychologists) to organize themselves and be co-owners in a service corporation and to organize as a professional partnership. *See* WIS. STAT. § 180.1901. Those health care providers whose professional negligence is covered by the Injured Patient and Families Compensation Fund might also organize as a limited liability company ("LLC") with minimal risk of compliance issues, although the law is less clear with respect to LLCs than with service corporations and professional partnerships.[2]

Failure to comply with CPOM and related fee splitting laws can have meaningful implications, such as: (i) physician licensure action or revocation; (ii) liability of non-physician business partners for engaging in medical practice without a license; (iii) voiding of an underlying

business arrangement for illegality; and (iv) recoupment of reimbursement payments by commercial or government insurers.[3] A violation of Wisconsin Medical Practice Act requirements may result in a fine of not more than $10,000 or imprisonment for not more than nine months, or for physicians specifically, a fine of not more than $25,000, with certain narrow exceptions. *See* WIS. STAT. § 448.09(1)-(1m).

Which jurisdiction's CPOM doctrine applies to a health care venture depends upon where the patients are located, which can be expansive if telemedicine is involved. Since telemedicine is frequently practiced across state lines, physician groups and telehealth businesses must structure their operations to account for the variability of the CPOM and fee splitting doctrines (and the degree of enforcement thereof) among jurisdictions. For example, New York's CPOM doctrine and related enforcement is strong comparative to Wisconsin law.[4]

Management Services Organizations

Compliance with the CPOM and fee-splitting doctrines becomes more complex when clinical telemedicine or medical technology businesses require equity financing from non-licensed investors.[5] A joint venture for telemedicine services may comply with CPOM and related laws by directing the investment by non-licensed persons or entities into a separate state-approved legal entity, often called a management services organization ("MSO"), that would provide non-clinical, administrative support services to physician group practices and other health care providers. The MSO would be compensated for any business and administrative services provided to the legally separate medical practice, excluding revenue earned directly from professional services fees. MSO support services can include areas such as: (i) financial management, budgeting and accounting services; (ii) information technology (IT) services; (iii) human resources and non-clinical personnel management; (iv) coding, billing and collection services; (v) providing and managing office space[6]; (vi) credentialing and contract management; (vii) vendor management and group purchasing; and (viii) marketing services.

In many jurisdictions, central to the analysis of compliance with the CPOM doctrine is the degree of control that the MSO exercises over the operation of the medical practice and/or the professional judgment of licensed health care professionals.[7] Note that even a high level of control over *business* decisions may be suspect in certain jurisdictions.[8] In Illinois, a direct correlation between the fee earned by the clinical practice and the amount paid to the MSO has been found to violate the CPOM laws in addition to the state's fee splitting statutes.[9] Because a MSO's degree of control over a medical practice may be effectuated by a confluence of multiple factors, and will ultimately be judged against a body of law which varies by jurisdiction (*i.e.,* where patients are located during treatment), all MSO arrangements should be evaluated by legal counsel for compliance purposes.

Fee Splitting Prohibitions

In addition to CPOM concerns, the compensation arrangement between the physician practice and the MSO must be structured to avoid state prohibitions against fee splitting with non-licensed persons or entities. Wisconsin's statutory fee splitting provision prohibits physicians from giving or receiving (directly or indirectly) any form of compensation or anything of value to a person, firm or corporation for inducing or referring a person to communicate with a licensee in a professional capacity or for professional services that were not personally rendered or at the direction of the other licensed professional. [10] *See* WIS. STAT. § 448.08(1m).

Fee splitting case law varies significantly based upon the law of the local jurisdiction, the specific types of business services provided by the MSO (*e.g.*, leasing of space and equipment, marketing, billing or other business and administrative services), and the compensation structure outlined in the management services agreement.[11] A threshold consideration is whether applicable state law permits fees paid to the MSO that are based upon a percentage of revenue earned from professional services. Some state fee splitting laws permit compensation based upon a percentage of revenue, so long as the consideration is commensurate with the value of services furnished.[12] On the other end of the spectrum, Illinois essentially views any percentage relationship with a physician or professional service corporation as a violation of fee splitting.[13] Additionally, if a MSO generates business or referrals for a medical services entity through marketing or similar services, and under the compensation structure provided by the management services agreement the MSO's marketing services ultimately increase the MSO's revenue stream from the medical services entity, then a management services arrangement is more likely to be scrutinized for illegality in states which enforce fee splitting prohibitions.[14]

In summary, if a telehealth business model depends directly or indirectly on revenues generated from physician services, rather than a technology license, legal analysis for compliance with the CPOM and fee splitting laws is advisable. In addition to legal counsel, a valuation expert should be consulted to ensure that the compensation paid to the non-licensed MSO under the management services agreement reflect the value of each of the various services actually provided by the MSO, rather than increased business volume or referrals.

Irrespective of whether telehealth services will be provided in jurisdictions where CPOM and/or fee splitting laws are strong (or strongly enforced), health care companies should note that the federal Stark or anti-kickback statutes could be implicated if an MSO is deemed to be referring business to the professional services corporation and fee is viewed as compensation for referrals.[15] Recent changes to the federal Stark and anti-kickback laws should generally benefit telehealth and remote patient monitoring; however, experienced legal counsel should be consulted regarding the impact of such fraud and abuse laws on the

business arrangement.[16]

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[1] *See* WIS. STAT. § 448.03(1) (requiring licensure by the Medical Examining Board to "practice medicine and surgery, or attempt to do so or make a representation as authorized to do so"); WIS. STAT. § 448.08(1m) (fee splitting prohibition). See also 71 Op. Att'y Gen. 108 (1982); 75 Op. Att'y Gen. 200 (1986) (widely criticized and ignored on certain grounds discussed herein).

[2] The Wisconsin Department of Regulation and Licensing, which was disbanded in 2011 and replaced by the Department of Safety and Professional Services ("DSPS"), had for years published frequently asked questions ("FAQ") guidance on its website that prohibited physicians from practicing medicine under an LLC or limited liability partnership ("LLP") form of business. The FAQ was based upon an AG opinion, 75 Op. Att'y Gen. 200 (1986), holding that physicians may not organize as business corporations, but note that LLCs and LLPs did not exist at the time of the AG opinion. This FAQ has been removed, as well as a subsequent FAQ that expressly stated that two or more physicians may enter into either partnerships or service corporations. *See* ANDREW G. JACK ET AL, AMERICAN HEALTH LAWYERS ASSOCIATION, CORPORATE PRACTICE OF MEDICINE: A 50-STATE SURVEY 570(2nd ed. 2020). The rationale for the 1986 AG opinion was that business corporations afforded broad limited liability for their members (no carve out for a member's own professional negligence, as is the case for a service corporation or general partnership). See Adam J. Tutaj, Wisconsin's Corporate Practice of Medicine Doctrine: Dead Letter, Trap for the Unwary, or Both?, STATE BAR OF WIS. PINNACLE, TRACK 3, SESSION 4 (Dec. 2019). In view of the current ambiguity under Wisconsin law with respect to LLCs, any two more medical professionals seeking to organize as an LLC confirm that patients can in fact be compensated for professional negligence by coverage by the Injured Patient and Families Compensation Fund for the area of medical practice at issue.

[3] *See generally* JACK ET AL., *supra* note 2.

[4] *See id*.

[5] Under Wisconsin law, the term "person" (required to obtain a license issued by the Medical Examining Board) extends to partnerships, associations, and corporations. See Wis. Stat. § 990.01(26). *See also* WIS. STAT. § 448.03(1).

[6] Whether a lease agreement between an MSO and a service provider entity is legal often

depends upon whether the relationship between lessor and lessee involves referrals. See JACK ET AL., *supra* note 2, at 136-37 (comparing *The Petition for Declaratory Statement of Melbourne Health Associates, Inc. and John Lozito, M.D.*, 9 FALR 6295 (1987), with *The Petition for Declaratory Statement of Joseph M. Zeterberg, M.D.*, 12 FALR 1036 (1990)).

[7] *See* e.g., 83 Op. Cal. Atty. Gen. 170 (July 27, 2000) (emphasizing the impossibility of distinguishing between professional and non-professional services when scrutinizing an arrangement between an MSO and a union whereby the MSO selected the radiology site and radiologist and paid for radiology diagnostic services for union members in exchange for a fee that included both the gross amount for professional services and the MSO's compensation); JACK ET AL., *supra* note 2, at 69.

[8] *See* e.g., *Andrew Carothers, M.D., P.C. v. Progressive Ins. Co.*, 2019 N.Y. Slip Op. 04643 (June 11, 2019). The New York Court of Appeals held that medical practices that give too much operational and financial control to MSOs are "fraudulently incorporated," and not entitled to reimbursement by no-fault auto insurers. See id. (cited by JACK ET AL., *supra* note 2, at 365-66).

[9] *See TLC The Laser Ctr., Inc. v. Midwest Eye Inst. II*, Ltd., 714 N.E.2d 45 (Ill. App. Ct. 1999) (concluding that where a service agreement provided for an annual fee to be paid to an unlicensed corporation, the arrangement illegally violated the corporate practice of medicine doctrine even where the fee was not a straight percentage, because there was a relationship between the amount of revenue earned and the fee paid).

[10] The Wisconsin Attorney General has issued an opinion that addresses fee splitting. See 71 Op. Att'y Gen. 108, 109 (1982) (asserting that the statutory prohibition against fee splitting was aimed at addressing "fees or commissions [that] were not for any services rendered to the patient, but purely a service rendered to the other physicians or surgeons in the way of sending them this business.")

[11] *See e.g., The Petition for Declaratory Statement of Edmund G. Lundy, M.D.*, 9 FALR 6289 (1987) (emphasizing the state statute's emphasis on prohibited *referrals* when finding no violation of the Florida fee-splitting prohibition under circumstances where a business entity provided office space, equipment, advertising and billing services to family practitioners in exchange for 40% of their respective collections) (cited in Jack et al., *supra* note 2, at 136); *TLC The Laser Ctr., Inc. v. Midwest Eye Inst. II*, Ltd., 714 N.E.2d 45, 56 (Ill. App. Ct. 1999) (finding that where a service agreement provided for an annual fee to be paid to an unlicensed corporation, the arrangement illegally violated the statutory prohibition against fee splitting, even where the fee was not a straight percentage, because "the fee clearly increased as revenues increased"); *Vine Street Clinic v. HealthLink, Inc.*, 856 N.E.2d 422, 434 (Ill. 2006) (holding that a corporation that creates a network of health care providers may receive a flat fee for administrative services, but not a percentage fee, for services

rendered). The Illinois Supreme Court reasoned that the flat fee did not implicate public policy concerns because the "flat fee is charged to each participating physician for administrative services rendered, not for referrals, and thus no 'recommendation' component exists." *Id*. at 435. Central to the court's ruling was the fact that the flat fee would not affect the treatment given to the patient. See JACK ET AL., *supra* note 2, at 168-69. See also *Ashley MRI Mgt. Corp. v. Perkes*, No. 001915-05, 2010 WL 441941(N.Y. Sup. Ct. Jan. 26, 2010). In this case, the court raised significant issues regarding a management relationship under which the non-licensed professional manager received a percentage of the "net revenue" earned by licensed health care professionals in connection with the subleasing of an MRI facility, concluding that such an arrangement "may be an illegal fee splitting arrangement." *Id*. The court in Ashley Management also questioned as a potentially illegal fee splitting arrangement an arrangement whereby one of the unlicensed business entities involved received a flat usage fee for each MRI or diagnostic scan performed by the licensed health professionals. The court explained that the direct sharing of radiology fees with a non-physician raises public policy concerns as to the quality of care and the corporate practice of medicine. See JACK ET AL., *supra* note 2, at 364.

[12] *See* e.g., California Business and Professions Code §650(b); *Epic Med. Mgmt., LLC v. Paquette*, 198 Cal.Rptr.3d 28 (Cal. Ct. App. 2015) (relying on §650(b) in a case in which the management company actually charged a fee equal to 50% of the revenue for office medical services, 25% of the revenue for surgical services and 75% of the revenue of pharmaceutical-related revenues) (cited in JACK ET AL., supra note 2, at 66).

[13] Illinois's Medical Practice Act prohibits direct or indirect payment of a percentage of the licensee's professional fees, revenues or profits to anyone for negotiating fees, charges or terms of service or payment on behalf of the licensee, among numerous other prohibited services. See 225 Ill. Comp. Stat. 60/22.2. The Illinois Medical Practice Act includes several exceptions, including paying fair market value for billing, administrative assistance or collection services. See JACK ET AL., *supra* note 2, at 165-66.

[14] *See* JACK ET AL., supra note 2, at 136-138, 168-69 (summarizing key Florida and Illinois case law defining each state's fee splitting prohibition and emphasizing the courts' concern with payments for developing affiliations with local clinical practices, marketing services and "practice expansion" services, as well as incentives to add patients to a practice, respectively) (citing *The Petition for Declaratory Statement of Joseph M. Zeterberg*, M.D. 12 FALR 1036 (1990); *The Petition for Declaratory Statement of Magan Bakarania, M.D.*, Final Order Issued October 17, 1997; *The Petition for Declaratory Statement of Dr. Gary Johnson, M.D. and The Green Clinic*, 14 FALR 3936 (November 30, 1990); *The Petition for Declaratory Statement of Rew, Rogers and Silver, M.D.'s, P.A.*, 12 FALR 4139, Final Order issued August 25, 1999; *Gold, Vann and White, P.A. v. Friedenstab*, 831 So. 2d 692 (Dist. Ct. App. 2002). *See also E&B Mktg. Enter., Inc. v. Ryan*, 568 N.E.2d 339, 341-42 (Ill. App. Ct. 1991) (determining that an illegal fee splitting arrangement existed under Illinois law where the

plaintiff was to receive a fee of 10% of all billings collected by the doctor in exchange for the plaintiff's advertising, which primarily targeted insurance companies); *Vine Street Clinic v. HealthLink, Inc.*, 856 N.E.2d 422 (Ill. 2006) (emphasizing that a flat service fee for administrative services reflected compensation for services actually rendered rather than compensation for referrals).

[15] *See* 42 U.S.C. §1395nn (Physician Self-Referral, or Stark law); 42 U.S.C. §1320a-7b(b) (Anti-Kickback statute). Note that health care ventures must also comply with state health care fraud and abuse statutes.

[16] *See* Medicare and State Health Care Programs: Fraud and Abuse; Revisions to Safe Harbors Under the Anti-Kickback Statute, and Civil Monetary Penalty Rules Regarding Beneficiary Inducements, 85 Fed. Reg. 77,684 (Dec. 2, 2020) (to be codified at 42 CFR pts. 1001, 1003), available at https://www.federalregister.gov/public-inspection/2020-26072/medicare-and-state-health-care-programs-fraud-and-abuse-revisions-to-safe-harbors-under-the (last accessed Feb. 22, 2021); Medicare Program; Modernizing and Clarifying the Physician Self-Referral Regulations, 85 Fed. Reg. 77,492 (Dec. 2, 2020) (to be codified at 42 C.F.R. pt. 411), available at https://www.federalregister.gov/public-inspection/2020-26140/medicare-program-modernizing-and-clarifying-the-physician-self-referral-regulations (last accessed Feb. 22, 2021).

HEALTH CARE LAW ADVISOR ALERT: TELEHEALTH IN WISCONSIN (PART 2 OF 2)

Medical Malpractice Risk and Telemedicine Policies

This article is the second of a two-part series on telehealth in Wisconsin. The first article of this series, available here, highlighted basic standards for regulatory compliance in the design of internal telehealth policies. This second article addresses the practitioner's obligation to minimize patient harm (and thus practitioner liability) with attention to the medical standard of care when assessing when and how telehealth is appropriate for each patient.

A. Maintaining Medical Standard of Care in Telemedicine

Wisconsin medical providers must critically evaluate whether their use of a telemedicine platform would permit their evaluation and treatment of each patient in compliance with "the

standard of minimally competent medical practice."[i] Standards of practice and conduct required for in-person visits, including standards relating to patient confidentiality and recordkeeping, must be observed in the telehealth context.[ii]

In view of these standards articulated by the Wisconsin medical examining board, internal telemedicine policies and procedures must preserve the same degree of quality and safety achieved during in person appointments. Clinical leadership must assess whether quality of patient care can be maintained via telehealth, an evaluation which is dependent upon the provider's area of specialty, the patient's condition, and other factors. For example, the use of telemedicine is not suitable for conditions where physical examinations are necessary, because of extreme symptoms, forceful interventions, or in the case of medical procedures for which certain protocols need to be followed.[iii]

Clinical guidelines specific to telemedicine can serve as important indicators as to whether your practice should incorporate telemedicine for specific patient encounters or diagnostic evaluations.[iv] However, guideline compliance does not guarantee accurate diagnosis or safe and effective medical care meeting the standard of care. Local circumstances must be considered, and the practitioner is ultimately responsible for all decisions regarding the appropriateness of a specific course of action.[v] Published guidelines for every clinical scenario and application simply do not exist and so by necessity may need to be developed in-house.[vi] The policies of each medical practice should delineate between circumstances in which various telehealth platforms can, and cannot, preserve the quality of care for patients. Providing treatment recommendations, including issuing a prescription, based only on a static electronic questionnaire does not meet the standard of minimally competent medical practice.[vii]

Sometimes the proper standard of care is reflected in government reimbursement decisions. For example, the Wisconsin Department of Health Services' ("DHS") expansion of telehealth coverage will exclude comprehensive assessment and care planning for children with complexities, since this requires an in-person assessment. However, case management for children with complex medical needs will be covered. Certain, but not all, dental evaluations will be covered. Certain therapy services will be covered.[viii]

Where clinical leadership determines that telehealth is appropriate, workflow must be re-evaluated in the telehealth context to maintain the standard of care. For example, staff responsibilities may require adjustment for telehealth encounters to ensure that updates to the medical record, physician orders and the "after visit summary" are properly recorded in connection with each telehealth encounter. Providers may consider requiring immediate scheduling of patients who express symptoms that require in-person evaluation during a telemedicine visit to promote patient safety and minimize liability. Providers might also consider whether patient/family coaching regarding medication administration is properly handled in the telehealth context.

B. Telephone and Texting: Risk Mitigation

While the use of synchronous audio and video visits has exploded in the wake of the COVID-19 pandemic, physicians have provided routine medical advice by phone for decades, responding to patient calls reporting a change in condition and advising medication changes by phone communications. Surveys of patients since the COVID-19 pandemic indicates that texting is a preferred method of communication over phone calls.[ix] In addition to health care privacy and security issues (outside of the scope of this article), what are some of the legal considerations for such telephone and texting encounters?

First, practitioners must observe the criteria for government and private insurer reimbursement of telehealth, unless their practice is limited to self-pay. In the case of Medicaid reimbursement, the Wisconsin Medical Assistance Program generally covers consultations through "interactive telehealth" and certain asynchronous telehealth services and remote patient monitoring.[x] The Wisconsin Statutes delegate authority to DHS to determine whether to include telephone encounters within the definition of "telehealth."[xi] DHS is temporarily providing coverage for certain telephone visits during COVID-19 pandemic, and the agency may ultimately decide to continue coverage of certain telephone communications as part of its permanent policy.[xii] Audio-only telephone communications must be delivered with the functional equivalency of a face-to-face encounter in order to be covered by Wisconsin Medicaid during the COVID-19 pandemic.[xiii]

If the patient will be located out-of-state, the provider must assess whether the applicable state's criteria for Medicaid telehealth reimbursement differs from the requirements imposed by Wisconsin Medicaid.[xiv] If federal Medicare will instead serve as payor, the Centers for Medicare and Medicaid Services ("CMS") will reimburse certain audio-only phone visits during the COVID-19 public health emergency. For reimbursement purposes, CMS distinguishes "telephone visits" from "services that "would normally occur in person." Telephone visits are "not paid as though the service occurred in person," and reimbursement may be bundled into a pre- or post-service if the phone encounter falls within the previous seven days of a prior visit or leads to a subsequent evaluation/management service.[xv]

Because audio-only telephone and texting encounters are inherently more limited with respect to patient evaluation capabilities, providers should exercise caution when using these modes of telehealth in circumstances that would usually *or could* warrant a physical evaluation of the patient based upon medical history or the symptoms described when scheduling an appointment. In addition to introducing risk of medical malpractice claims, providers risk non-compliance with criteria for reimbursement, such the standard of "functional equivalency to the face-to-face service" required by state Medicaid for reimbursement. The "functional equivalency standard" applicable to state government reimbursement is higher than the "the standard of minimally competent medical practice" generally applicable to the practice of telemedicine in the state.[xvi]

C. Updates to Telehealth Policies and Procedures

Irrespective of whether government reimbursement is in play, your medical practice policies and procedures should be updated to mitigate risk to patient care and safety in the telehealth context. Your internal policies and procedures should delineate between when telemedicine is (and is not) appropriate based upon a critical assessment of each of the several evaluative and diagnostic services provided by your practice. Staff, including schedulers and nurses, should be trained as to when scheduling a telemedicine appointment poses risk to your patients and your practice. Your policies should incorporate customized procedures designed to preserve the standard of care and the medical recordkeeping requirements imposed by the Wisconsin medical examining board for the practice of telemedicine. In addition, physicians practicing telemedicine should confirm that their medical malpractice insurance coverage applies outside of the traditional health care facility settings.

OCHDL's health care practice group will continue to monitor telehealth regulations and related guidance as the standard of care for telemedicine evolves. For more information on this topic, contact Marguerite Hammes at 414-276-5000 or marguerite.hammes@wilaw.com.

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[i] ***See*** **WIS. ADMIN. CODE § MED 24.06.**

[ii] ***See*** **WIS. ADMIN. CODE § MED 24.05. (requiring the same standard of practice and conduct regardless of whether health care services are provided in person or by telemedicine). The standard of care that is required of all Wisconsin health care providers is defined as the degree of skill, care, and judgment which reasonable health care providers who practice the same specialty would exercise in the same or similar circumstances, having due regard for the state of medical science at the time.** ***Nowatske v. Osterloh*****, 198 Wis.2d 419, 543 N.W.2d 25 (1996),** ***abrogated on other ground by Nommensen v. American Continental Ins. Co.*****, 246 Wis.2nd 132, 629 N.W.2d 132 (2001); Wis. J.I. Civil No. 1023.**

[iii] Secure Medical, Best Telemedicine Clinical Guidelines (April 13, 2018), available at https://www.securemedical.com/telemedicine/best-telemedicine-clinical-guidelines/

[iv] ***E.g.,*** **American Telemedicine Association, Practice Guidelines Archives, available at https://www.americantelemed.org/resource_categories/practice-guidelines/ ; Pantanowitz, Liron et al. "American Telemedicine Association clinical guidelines for telepathology." Journal of pathology informatics vol. 5,1 39. 21 Oct. 2014, doi:10.4103/2153-3539.143329; Krupinski, Elizabeth A, and Jordana Bernard. "Standards and Guidelines in Telemedicine and Telehealth." Healthcare (Basel, Switzerland) vol. 2,1 74-93. 12 Feb. 2014, doi:10.3390/healthcare2010074.**

[v] Elizabeth A. Krupinski and Jordana Bernard, Standards and Guidelines in Telemedicine and Telehealth, Healthcare 2014, 2, 74-93; doi: 10.3390/healthcare2010074, at 81.

[vi] ***See*** **Standards and Guidelines in Telemedicine and Telehealth, Healthcare, supra note 5, at 81.**

[vii] ***See*** **WIS. ADMIN. CODE § MED 24.07 (2).**

[viii] ***See*** **Brook Anderson, Wisconsin DHS Benefits Policy Section Chief, Telehealth Expansion: Acute and Primary Services, available at https://www.dhs.wisconsin.gov/telehealth/telehealth-expansion-all-provider.pdf (revised July 30, 2020).**

[ix] SR Heath, Patient Communication Preferences: the COVID-19 Impact, July 30, 2020, available at https://mhealthintelligence.com/resources/white-papers/patient-communication-preferences-the-covid-19-impact eid=CXTEL000000554482&elqCampaignId=16139&utm_source=ded&utm_medium=email&utm_campaign=dedicated&elqTrackId=607a1670c3c349349ac195f03c60cba2&elq=362f09f490fe41169f2fc16dbcab5410&elqaid=16904&elqat=1&elqCampaignId=16139

[x] ***See*** **WIS. STAT. § 49.46(2)(b)(21)-(22).**

[xi] ***See*** **WIS. STAT. § 49.45(61)(a)(4); §49.46(2)(b)(23).**

[xii] ***See*** **ForwardHealth Update 2020-12, "Temporary Changes to Telehealth Policy and Clarifications for Behavioral Health and Targeted Case Management Providers" (revised May 8, 2020), available at https://www.forwardhealth.wi.gov/kw/pdf/2020-12.pdf**

[xiii] ***See id*****.**

[xiv] ***See*** **Center For Connected Health Policy, State Telehealth Laws and Reimbursement Policies (Fall 2020), available at https://www.cchpca.org/sites/default/files/2020-10/CCHP%2050%20STATE%20REPORT%20FALL%202020%20FINAL.pdf**

[xv] ***See, e.g.,*** **Centers for Medicare and Medicaid Services, COVID-19 Frequently Asked Questions (FAQs) on Medicare Fee-For-Service (FFS) Billing (revised October 20, 2020), at 63-79, available at https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf**

[xvi] ***Compare*** **Wisconsin ForwardHealth Telehealth Expansion and Related Resources for Providers, available at https://www.forwardhealth.wi.gov/WIPortal/content/html/news/telehealth_resources.html.spage , *with* WIS. ADMIN. CODE § MED 24.06.**

HEALTH CARE LAW ADVISOR ALERT: TELEHEALTH IN WISCONSIN (PART 1 OF 2)

I. Expansion of Telehealth to Meet Clinical Need

Federal and state governments have resolved traditional barriers to telehealth – including complexity of billing, lower reimbursement and privacy and security concerns – to facilitate the safe provision of medical services during the COVID-19 pandemic.[i] The first article in this two-part series highlights basic standards for regulatory compliance in the design of telehealth policies. The second article will address the practitioner's obligation to minimize patient harm (and thus practitioner liability) with attention to the medical standard of care

when assessing when and how telehealth is appropriate for each patient.

II. Mechanics of Telehealth Compliance

A. Minimum Standards for Telehealth Practice

A Wisconsin physician planning to provide treatment recommendations (including a prescription) by use of a website-based platform must observe requirements promulgated by the Wisconsin medical examining board to comply with state law and (when applicable) to receive payment from Wisconsin Medicaid.[ii] While the requirement that the physician be licensed to practice medicine in the state has been suspended during the COVID-19 emergency,[iii] the following formalities must still be observed during the pandemic to protect the integrity of the telemedicine encounter:

1. Physician's name and contact information must be made available to the patient;
2. Informed consent must be obtained;[iv]
3. A documented evaluation (including a medical history) must be performed. If needed to satisfy standards of minimally competent medical practice, an examination, evaluation, and/or diagnostic tests are also required.
4. A patient health care record must be prepared and maintained.[v]

Under permanent Wisconsin telemedicine regulations, a physician-patient relationship may be initially established by use of two-way electronic communications, but not by use of audio-only telephone, email messages or text messages.[vi] Conditioning treatment of a patient upon the use of telehealth is expressly prohibited.[vii]

B. Reimbursable Telehealth Services

1. Wisconsin Medicaid and Telehealth

Wisconsin lawmakers began expanding the services and communications that may be provided by telehealth prior to the COVID-19 pandemic. The Wisconsin Department of Health Services ("DHS") continues to broaden the range of medical services covered by the state's medical assistance program when delivered remotely, both during the public health emergency and beyond.[viii] DHS is adding Medicaid coverage for *currently covered services* when provided using a telehealth platform if *functionally equivalent to an in-person visit* (interactive synchronous technology).[ix] DHS's criteria for "face-to-face equivalence" for interactive telehealth services includes the use of "audio, video, or telecommunication technology," but only if there is "no reduction in quality, safety, or effectiveness."[x] Audio-only phone communication that can be delivered with a functional equivalency to face-to-face service will be covered during the COVID-19 pandemic.[xi] DHS emphasizes that documentation must support the service rendered.[xii] For further explanation of these

policies, visit ForwardHealth, Telehealth, Telehealth Expansion and Related Resources for Providers.[xiii]

Telehealth coverage expansion applies to all services currently indicated in topic (#510) of the FowardHealth Online Handbook (permanent policy), and additional services temporarily allowed for telehealth are published in ForwardHealth Updates.[xiv] For example, ForwardHealth is expanding coverage to include certain synchronous (real-time) and asynchronous (not real-time) services such as remote patient monitoring and provider-to-provider consultations. DHS also plans to roll out expansion updates particular to specific services areas, such as therapy and behavioral health. DHS will use a phased approach to its expansion of telehealth services, keeping providers informed of expansion of coverage via the ForwardHealth website described above.

In addition to coverage criteria relating to the mode of telehealth services, a provider must be mindful of rules governing the logistics of telehealth visits. Wisconsin Medical Assistance (Medicaid) places no restriction on the location of the provider (permanent policy), which may include physicians, nurse practitioners, Ph.D. psychologists, psychiatrists and others.[xv] Beginning in March 2020, ForwardHealth began allowing coverage irrespective of the location of the patient (permanent policy).[xvi] However, only the following sites are currently eligible for a facility fee: hospitals, including emergency departments, office/clinics, and skilled nursing facilities.[xvii]

2. Federal Medicare and Telehealth

The Centers for Medicare and Medicaid Services ("CMS") greatly expanded access to Medicare telehealth services based upon the regulatory flexibilities granted under Social Security Act § 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act. Currently, Medicare will reimburse both synchronous video visits and also brief communication technology-based services ("CTBS") for responses to Medicare Part B beneficiaries by telephone, audio/video, secure text messaging or by use of a patient portal.[xviii] Reimbursement for CTBS is limited to patients with an established (or exiting) relationship with a physician or certain practitioners. The billing codes for CTBS represent ***brief, patient-initiated*** communication services and do not replace full evaluation and treatment services covered under the Medicare benefit and described by existing CPT codes. To meet the criteria for medical necessity, CTBS must require clinical decision-making and not be for administrative or scheduling purposes. The patient must verbally consent to these types of services at least annually.

To be covered by Medicare, the CTBS must not be related to a medical visit within the previous seven (7) days and cannot lead to a medical visit within the next twenty-four (24) hours (or soonest appointment available).[xix] For Medicare reimbursement, providers must

confirm that the particular diagnostic benefit falls within the description of CTBS codes. For example, CTBS codes do not include the audiology diagnostic benefit category.[xx] DHS applies similar requirements to billing for "telephone evaluation and management services" covered under Wisconsin Medicare.[xxi]

During the COVID-19 pandemic, Medicare will reimburse telehealth services at the same rate as regular, in-person visits. The level of reimbursement that is approved following the public health emergency will impact the availability of telehealth services.

C. Documentation Requirements

DHS policy (published via ForwardHealth updates available online) is to require that all services provided via telehealth be thoroughly documented in the member's medical record in the same manner as services provided face-to-face.[xxii] Providers must develop and implement their own methods of informed consent to confirm that a member agrees to receive services via telehealth. ForwardHealth considers verbal consent to receiving services via telehealth an acceptable method of informed consent when it is documented in the member's medical record.[xxiii] Documentation for originating sites (patient location) must support the member's presence in order to submit a claim for the originating site facility fee. In addition, if the originating site provides and bills for services and also the originating site facility fee, documentation in the member's medical record should distinguish between the unique services provided.[xxiv]

DHS is temporarily allowing supervision requirements for paraprofessional providers to be met via telehealth. Supervision must be documented according to existing benefit policy.[xxv]

III. Additional Considerations for Telehealth

E-Prescribing – Many states limit the prescribing of controlled substances based solely on telehealth examination. Generally speaking, the U.S. Drug Enforcement Administration ("DEA") requires a telemedicine provider to have an in-person medical evaluation of a patient prior to prescribing a controlled substance for the patient, absent an exception. However, the DEA issued notice in March 2020 that this requirement is waived for the duration of the COVID-19 public health emergency.[xxvi]

Privacy and Security – The Office for Civil Rights announced on March 17, 2020 that they will not impose penalties for noncompliance with the Health Insurance Portability and Accountability Act of 1996 regulatory requirements for remote communications technologies in connection with the good faith provision of telehealth during the national COVID-19 public health emergency. DHS has issued an update clarifying guidance regarding federal enforcement of the Health Insurance Portability and Accountability Act of 1996 regulatory

requirements during the COVID-19 pandemic.[xxvii]

Practicing Telehealth Across State Lines **–** Wisconsin has adopted the Federation of State Medical Boards' Interstate Licensure Compact, which aims to expediate physician licenses for uses like telemedicine in states that adopt the compact. Wisconsin providers serving patients in other states must consult local state laws governing the physician-patient relationship and the use of telemedicine.

When a Wisconsin provider provides telemedicine services to a patient located outside of the state, legal review for choice of law and choice of forum should be undertaken. For example, the laws of the state in which each patient is located should be evaluated for: (1) statute of limitations; (2) standard of care; (3) limitations of liability; and (4) unique provisions governing the establishment or termination of the physician/patient relationship. To manage these challenges in a large telemedicine practice, a provider may need to consider establishing different legal entities for the practice of medicine in different states.

OCHDL will continue to monitor changes in regulations and policy impacting telemedicine. Our next blog post will address medical malpractice risk and telemedicine policies. For more information on these topics, contact Marguerite Hammes at 414-276-5000 or marguerite.hammes@wilaw.com.

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[i] SR Health, A Complete Guide to Seeing Patients Virtually and Getting Paid for It, available at https://www.srhealth.com/resources/telemedicine-guide

[ii] *See* WIS. ADMIN. CODE § MED 24.07 (1).

[iii] In the ordinary course, a physician practicing telemedicine in Wisconsin must be licensed to practice medicine and surgery by the medical examining board as required by Wis. Admin. Code § MED 24.04. *See* Wis. Admin. Code § MED 24.07 (1). However, Wis. Admin. Code § MED 24.04 (requiring a physician practicing medicine in Wisconsin to be licensed by the medical examining board) and 24.07(1)(a) (applying licensing requirements to medical practice by telemedicine in the state) have been suspended during the COVID-19 emergency. *See* Governor Tony Evers Emergency Order #16 Related to Certain Health Care Providers and the Department of Safety and Professional Services Credentialing, dated March 27, 2020.

[iv] WIS. ADMIN. CODE § MED 24.07 (1) (citing WIS. STAT. § 448.30 and Ch. MED. 18).

[v] WIS. ADMIN. CODE § MED 24.07(1) (citing ch. MED. 21).

[vi] *See id.* § MED 24.03.

[vii] ForwardHealth Update No. 2020-09, "Changes to ForwardHealth Telehealth Policies for Covered Services,

Originating Sites, and Federally Qualified Health Centers" (March 18, 2020).

[viii] ***See*** **WIS. STAT. § 49.45(61)(b); § 49.46(2)(b)(21)-(23). DHS is expanding the permanent definition of telehealth to encompass the "practice of health care delivery, diagnosis, consultation, treatment, or transfer of medically relevant data by means of audio, video, or data communications that are used either during a patient visit or consultation or are used to transfer medically relevant data about a patient." *See* ForwardHealth, Telehealth, Telehealth Expansion and Related Resources for Providers, available at https://www.forwardhealth.wi.gov/WIPortal/content/html/news/telehealth_resources.html.spage *See also* Letter to ForwardHealth Providers from Jim Jones, State Medicaid Director, re: Wisconsin Medicaid Response to the COVID-19 Outbreak; FowardHealth #510.**

[ix] ***See*** **ForwardHealth Update 2020-09, *supra* note vii (permanent policy); ForwardHealth Update 2020-12, "Temporary Changes to Telehealth Policy and Clarifications for Behavioral Health and Targeted Case Management Providers" (Revised May 8, 2020); ForwardHealth Update 2020-15, "Additional Services to be Provided Via Telehealth" (Revised May 8, 2020) (temporary expansion policy). *See also* Brooke Anderson, Benefits Policy Section Chief, Telehealth Expansion: Acute and Primary Services, available at https://www.dhs.wisconsin.gov/telehealth/telehealth-expansion-all-provider.pdf**

[x] ***See*** **ForwardHealth, Telehealth, Telehealth Expansion and Related Resources for Providers, *supra* note viii. *See also* Brooke Anderson, Benefits Policy Section Chief, Telehealth Expansion: Acute and Primary Services, *supra* note ix.**

[xi] **ForwardHealth Update 2020-12, *supra* note ix.**

[xii] **ForwardHealth, Telehealth, Telehealth Expansion and Related Resources for Providers, *supra* note viii.**

[xiii] **For further explanation of these policies, visit ForwardHealth, Telehealth, Telehealth Expansion and Related Resources for Providers, *supra* note viii. *See also* Brooke Anderson, Benefits Policy Section Chief, Telehealth Expansion: Acute and Primary Services, *supra* note ix.**

[xiv] **ForwardHealth Update 2020-15, *supra* note ix.**

[xv] **ForwardHealth Update 2020-12, *supra* note ix (permanent policy with respect to provider location but temporary with respect to other policy changes).**

[xvi] **ForwardHealth Update 2020-09, *supra* note ix (permanent policy changes).**

[xvii] **ForwardHealth, Topic 510, Telehealth, available at https://www.forwardhealth.wi.gov/WIPortal/Subsystem/KW/Print.aspx?ia=1&p=1&sa=1&s=2&c=61&nt=Telehealth**

[xviii] **Centers for Medicare and Medicaid Services, Medicare Telemedicine Health Care Provider Fact Sheet, available at https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet**

[xix] ***See id.***

[xx] **American Speech-Language-Hearing Association, Use of Communication Technology-Based Services During Caronavirus/COVID-19 (June 6, 2020), available at https://www.asha.org/Practice/reimbursement/medicare/Use-of-E-Visit-Codes-for-Medicare-Part-B-Services-During-Coronavirus/**

[xxi] **ForwardHealth Update 2020-09, *supra* note vii.**

[xxii] **ForwardHealth Update 2020-12, *supra* note ix (citing Wis. Admin. Code § DHS 106.02(9); ForwardHealth Online Handbook #201 (Financial Records), #202 (Medical Records); #203 (Preparation and Maintenance of**

Records); #204 (Records Retention); #1640 (Availability of Records to Authorized Personnel)).

[xxiii] *See* ForwardHealth Update 2020-15, *supra* note ix.

[xxiv] *See* ForwardHealth Update 2020-12, *supra* note ix.

[xxv] *See id.*

[xxvi] DEA Press Release, DEA's Response to COVID-19 (March 20, 2020), available at https://www.dea.gov/press-releases/2020/03/20/deas-response-covid-19

[xxvii] *See* ForwardHealth Update 2020-12, *supra* note ix.

OCHDL CREATES NEW HEALTH CARE LAW BLOG

Welcome to the first edition of the O'Neil, Cannon, Hollman, DeJong and Laing Health Care Law Advisor. We have created this blog as an informational and educational resource for our clients and contacts. The health care industry changes often and quickly, and we seek to help keep you apprised of important legal developments in the health care field.

Over the past few months, we have spent significant time advising clients on issues relating to the COVID-19 pandemic. We include in this inaugural blog post links to some of our recent writings regarding COVID-19 issues, including links of two cover stories in *The Wisconsin Lawyer* magazine. *The Wisconsin Lawyer* is the monthly publication of the State Bar of Wisconsin and addresses issues of interest throughout the state and country.

Christa Wittenberg and Grant Killoran authored the cover article in the April, 2020 edition of *The Wisconsin Lawyer* entitled "Due Process in the Time of the Coronavirus." Their article analyzes legal concepts governing the measures utilized by public health officials to combat an outbreak of contagious disease, focusing on COVID-19. Their article can be found here.

Grant Killoran, Joe Newbold and Erica Reib authored the cover article in the June, 2020 edition of *The Wisconsin Lawyer* magazine entitled "The New Wave of Litigation: An Early Report on COVID-19 Claims." Their article analyzes the types of claims being made related to the COVID-19 pandemic. Their article can be found here.

We also include a link to a recent article on our firm's Employment LawScene blog related to the COVID-19 pandemic entitled IRS Says Reduced-Cost or Free COVID-19 Testing or Treatment Won't Prevent Individuals from Making or Receiving HSA Contributions.

Lastly, in conjunction with last week's start of the Major League Baseball season, we include a link to an article recently posted in our newsroom by Attorney Pete Faust entitled COVID-19

Raises Privacy Issues for Major-League Baseball. The article discusses not only the current state of privacy policy in the baseball world, but also reviews the obligations of other businesses under the ADA, FMLA, CARES Act, GINA, and HIPAA.

We hope you enjoy this blog. If you have any questions about any of the articles or issues discussed in it, please feel free to contact the authors.